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	, 1						

APPENDIX 1 HOME HEALTH AND PRIVATE DUTY NURSING PROCEDURE CODES

Procedure Code	Place of Service	Type of Service	Service
W9919	4	1	Home Health - Physical Therapy
W9920	4	1	Home Health - Occupational Therapy
W9921	4	1	Home Health - Speech Therapy
W9925	4	1	Ongoing Assessment
W9930	4	1	Home Health Nursing Initial Visit
W9931	4	1	Home Health Aide Initial Visit
W9940	4	1	Home Health Nursing Subsequent Visit
W9941	4	1	Home Health Aide Subsequent Visit
W9045	0,4	1	Private Duty LPN
W9046	0,4	1	Private Duty RN
W9030*	0,4	1	Private Duty LPN
W9031*	0,4	1	Private Duty RN

^{*} When used for services to recipients under age 21, these codes will price at higher rates.

APPENDIX 2 LIST OF FORMS TO BE SUBMITTED WITH PA/RF

<u>Discipline</u>	Form(s)
Home health nursing	HCFA 485 - required with new and renewal requests HCFA 486 - required with new and renewal requests, and required with amendments, unless the HCFA 486 submitted with the approved PA/RF is still current. HCFA 487 - optional
Home health aide	HCFA 485 - required with new and renewal requests HCFA 486 - required with new and renewal requests, unless a Home Care Assessment or Home care Assessment Update is submitted; and required with amendments, unless the HCFA 486 submitted with the approved PA/RF is still current, or a Home Care Assessment Update is submitted because a Home Care Assessment was previously submitted. HCFA 487 - optional
Home health therapies	PA/HHTA - required with new and renewal requests INITIAL THERAPY EVALUATION or summary of recent re-evaluation - required with all requests HCFA 485 - required with new and renewal requests HCFA 486 - optional HCFA 487 - optional IEP - Individualized Education Plan required for child (0-21), or document why none IFSP - Individualized Family for Service Plan required for any child participating in the Birth to Three Program
Private duty nursing	HCFA 485 - required with new and renewal requests HCFA 486 - required with all requests, including amendments HCFA 487 - optional
Personal care worker	Home Care Assessment - required with requests Home Care Assessment Update - required with renewal requests, including amendments Physician's Orders or HCFA 485
Durable medical equipment	PA/DMEA - required with all requests HCFA 485 - required with new and renewal requests Physician Orders - required with amendments HCFA 486 - optional HCFA 487 - optional

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APPENDIX 3 INSTRUCTIONS FOR THE COMPLETION OF THE PRIOR AUTHORIZATION REQUEST FORM (PA/RF)

ELEMENT 1 - PROCESSING TYPE

Enter the appropriate three-digit processing type from the list below. The "process type" is a three-digit code used to identify a category of service requested. <u>Use 999 - "Other" only if the requested category of service is not found in the list.</u> Prior Authorization and Spell of Illness requests will be returned without adjudication if no processing type is indicated.

- * 120 Home Health/Private Duty Nursing Services/Home Health Therapy/Respiratory Care Services
 - 121 Personal Care Services
 - 130 Durable Medical Equipment
 - 131 Drugs
 - 132 Disposable Medical Supplies
 - 999 Other (use only if the requested category of service is not listed above)
- * Includes PT, OT, Speech, and may include personal care provided by dually-certified home health agencies

ELEMENT 2 - RECIPIENT'S MEDICAL ASSISTANCE IDENTIFICATION NUMBER

Enter the ten-digit Medical Assistance recipient identification number as found on the recipient's Medical Assistance identification card.

ELEMENT 3 - RECIPIENT'S NAME

Enter the recipient's last name, followed by first name and middle initial, exactly as it appears on the recipient's Medical Assistance identification card.

ELEMENT 4 - RECIPIENT'S ADDRESS

Enter the address of the recipient's place of residence; the street, city, state, and zip code must be included.

ELEMENT 5 - RECIPIENT'S DATE OF BIRTH

Enter the recipient's date of birth in MM/DD/YY format (e.g., June 8, 1941, would be 06/08/41), as it appears on the recipient's Medical Assistance identification card.

ELEMENT 6 - RECIPIENT'S SEX

Enter an "X" to specify male or female.

ELEMENT 7 - BILLING PROVIDER'S NAME, ADDRESS AND ZIP CODE

Enter the name and complete address (street, city, state, and zip code) of the billing provider. No other information should be entered in this element since it also serves as a return mailing label.

ELEMENT 8 - BILLING PROVIDER'S TELEPHONE NUMBER

Enter the telephone number, including the area code, of the office, clinic, facility, or place of business of the billing provider.

ELEMENT 9 - BILLING PROVIDER'S MEDICAL ASSISTANCE PROVIDER NUMBER

Enter the eight-digit Medical Assistance provider number of the billing provider.

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ELEMENT 10 - RECIPIENT'S PRIMARY DIAGNOSIS

Enter the appropriate International Classification of Disease, 9th Edition, Clinical Modification (ICD-9-CM) diagnosis <u>code</u> and <u>description most</u> relevant to the recipient's current medical condition.

ELEMENT 11 - RECIPIENT'S SECONDARY DIAGNOSIS

Enter the appropriate International Classification of Disease, 9th Edition, Clinical Modification (ICD-9-CM) diagnosis <u>code</u> and <u>description</u> additionally descriptive of the recipient's clinical condition.

ELEMENT 12 - START DATE OF SPELL OF ILLNESS (Not Required)

ELEMENT 13 - FIRST DATE OF TREATMENT (Not Required)

ELEMENT 14 - PROCEDURE CODE(S)

Enter the appropriate Revenue, HCPCS, or National Drug Code (NDC) procedure code for each service/procedure/item requested, in this element. When the procedure may be one of two at any given time, request both procedure codes (W9045/W9046, W9930/W9940).

ELEMENT 15 - MODIFIER

Enter the modifier corresponding to the procedure code (<u>if a modifier is required by WMAP policy and the coding structure</u> used) for each service/procedure/item requested.

ELEMENT 16 - PLACE OF SERVICE

Enter the appropriate place of service code designating where the requested service/procedure/item would be provided/performed/dispensed.

<u>Code</u>	Description
0	Other
4	Home

ELEMENT 17 - TYPE OF SERVICE

Enter the appropriate type of service code for each service/procedure/item requested.

Numeric	<u>Description</u>
1	Medical (including: Home Health, Independent Nurses, PT, OT, ST, Personal Care, Respiratory Care)
P	Purchase New DME
R	DME Rental

ELEMENT 18 - DESCRIPTION OF SERVICE

Enter a written description corresponding to the appropriate Revenue, HCPCS or National Drug Code (NDC) procedure code for each service/procedure/item requested.

When requesting home health services, indicate the number of visits per day/number of days per week times the total number of weeks being requested.

When requesting personal care or private duty nursing services, indicate the number of hours per day/number of days per week times the total number of weeks being requested.

If sharing a case with another provider, enter "shared case" and include a statement that the total number of hours of all providers will not exceed the combined total number of hours ordered on the PPOC.

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When requesting two procedure codes to be used interchangeably (W9045/W9046), include a statement that the total number of hours will not exceed the combined total number of hours ordered on the PPOC.

When requesting permission to bill for multiple visits when only one visit is provided, enter "Authorization requested to bill for (number of) subsequent Home Health Aide visits due to (number of) continuous hours of care."

ELEMENT 19 - QUANTITY OF SERVICE REQUESTED

Enter the quantity (e.g., number of services, dollar amount) requested for each service/procedure/item requested.

Disposable Medical Supplies (number of days supply)

Drugs (number of days supply)

Durable Medical Equipment (number of services)

Home Health (number of visits)

Home Health Therapy-PT, OT, Speech (number of visits)

Personal Care (number of hours)

Private Duty Nursing (number of hours)

Respiratory Care Services (number of hours)

For home health services based on visits, providers must figure the quantity of visits as follows:

- 1. Total each procedure code separately.
- 2. Count the actual number of days requested. (Use of the Julian Calendar is easiest: subtract the start date from the end date and add one more day.)

When one visit per day is requested, the actual number of days in the authorization period equals the total number of visits requested.

- 3. Divide the total number of days approved by 7 to determine the number of weeks. If the answer is not a whole number, round up to the next whole number.
- 4. Calculate, for each code, the total number of days per week.
- 5. Multiply the total of visits approved per procedure code by the number of days per week, then multiply this total by the number of weeks requested.

Example

1. A prior authorization request is submitted as follows:

Procedure code:

W9930 - 1v/day, 3 days/week W9931 - 1v/day, 7 days/week

2. Total days requested:

Start Date 6/5/91 End Date 12/31/91

Total days requested = 200

3. Total weeks requested:

```
200/7 = 28.6, round up to 29 weeks
```

4. Total services requested:

```
W9930 - 3 visits per week x 29 weeks = 87 visits W9931 - 1 visit per day x 200 days = 200 visits
```

For private duty nursing, respiratory care, and personal care services based on hours, providers must figure the quantity of hours as follows:

- 1. Total each procedure code separately.
- 2. Count the actual number of days requested. (Use of the Julian Calendar is easiest: subtract the start date from the end date <u>and</u> add one more day.)
- 3. Divide the total number of days requested by 7 to determine the number of weeks. If the answer is not a whole number, round up to the next whole number.
- 4. Calculate, for each code, the total number of days per week.
- 5. Multiply the total of hours approved per procedure code by the number of days per week, then multiply this total by the number of weeks requested.

Example

1. A prior authorization request is submitted as follows:

Procedure code:

```
W9045 - 4hrs./day, 3 days/week
W9046 - 7hrs./day, 7 days/week
```

2. Total days requested:

Start Date 6/5/91 End Date 12/31/91

Total days requested = 200

3. Total weeks requested:

```
200/7 = 28.6, round up to 29 weeks
```

4. Total services requested:

```
W9045 - 4 hours per day, 3 days per week x 29 weeks = 348 hours W9046 - 7 hours per day x 200 days = 1,400 hours
```

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ELEMENT 20 - CHARGES

Enter your usual and customary charge for each service/procedure/item requested. If the quantity is greater than "1", multiply the quantity by the charge for each service/procedure/item requested. Enter that total amount in this element.

NOTE:

The charges indicated on the <u>request form</u> should reflect the provider's usual and customary charge for the procedure requested. Providers are reimbursed for authorized services according to <u>Terms of Provider Reimbursement</u> issued by the Department of Health and Social Services.

ELEMENT 21 - TOTAL CHARGE

Enter the anticipated total charge for this request.

ELEMENT 22 - BILLING CLAIM PAYMENT CLARIFICATION STATEMENT

"An approved authorization does not guarantee payment. Reimbursement is contingent upon eligibility of the recipient and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after authorization expiration. Reimbursement will be in accordance with Wisconsin Medical Assistance Program payment methodology and Policy. If the recipient is enrolled in a Medical Assistance HMO at the time a prior authorized service is provided, WMAP reimbursement will be allowed only if the service is not covered by the HMO.

ELEMENT 23 - DATE

Enter the month, day, and year (in MM/DD/YY format) the prior authorization request form was completed and signed.

ELEMENT 24 - REQUESTING PROVIDER'S SIGNATURE

The signature of the provider requesting/performing/dispensing the service/procedure/item must appear in this element.

In the blank space to the right of element 24, please indicate the start and end date for which services are being requested. (Not required for DME/DMS items.)—If backdating is requested, specify backdating and indicate reason for need.

NOTE: The dates indicated for requested start and end dates do not guarantee the same authorization grant and expiration date.

DO NOT ENTER ANY INFORMATION BELOW THE SIGNATURE OF THE REQUESTING PROVIDER -- THIS SPACE IS RESERVED FOR THE WISCONSIN MEDICAL ASSISTANCE PROGRAM CONSULTANT(S) AND ANALYST(S).

APPENDIX 4 SAMPLE PRIOR AUTHORIZATION REQUEST FORM (PA/RF) PRIVATE DUTY NURSING SERVICES

MAIL TO: E.D.S FEDERAL CORPO PRIOR AUTHORIZATION 6406 BRIDGE ROAD SUITE 88 MADISON, WI 53784-00 2 RECIPIENT'S MEDICAL ASSIST 1234567890 3 RECIPIENT'S NAME (LAST, FIR RECIPIENT'S NAME (LAST, FIR SOUTH OF BIRTH MM/DD/YY	BBB DANCE ID NU		609 Willow Anytown, WI 55555 BELLING PROVIDER TELEPHONE NUMBER (XXX) XXX—XXXXX						120
7 BILING PROVIDER NAME. ADI I.M.Provider 10 W. Williams Anytown, WI 55		Tse	117	18			12 START DATE OF MM/DD/YY	draplegia v nary trac so:	t infection 13 FIRST DATE RX: MM/DD/YY
PROCEDURE CODE	MOD	POS	TOS		DESCRIPT	ION OF SERV	NGE	QR	CHARGES
W9045/W9046		4	1	8 hrs/d	hours not	ys/week	x 25 weeks	1400	XXX
22. An approved authorizat Reimbursement is continge recipient and provider at for services initiated prior Assistance Program pays	the time to appro nent meth	the ser val or af nodology	of the vice is ter auth and Po	provided ar orization ex licy. If the	piration date. recipient is	Reimbursen enrolled in	nent will be in ac a Medical Assist	CHARGE ation. Paymer cordance wit tance HMO	h Wisconsin Medical
authorized service is provi	ded, WMA	P reimbu	rsement	M. K	rouides	e service is r	not covered by the	sta	art: MM/DD/YY and: MM/DD/YY
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RETURN - RE	ASON:		cc	INSULTANT/AN	VALYST SIGNATU	RE			

APPENDIX 4a SAMPLE PRIOR AUTHORIZATION REQUEST FORM (PA/RF) HOME HEALTH NURSING SERVICES

MAIL TO:			PF PF	RIOR AUTHORIZATION REQUES	T FORM		1 PRC	CESSING TYPE
E.D.S. FEDERAL CORPO	ORATION			PA/RE (DO NOT WRITE IN			_	10000000000000000000000000000000000000
PRIOR AUTHORIZATION	N UNIT			PA/RF (DO NOT WRITE III				
6406 BRIDGE ROAD				120				
SUITE 88								
MADISON, WI 53784-00	880			A.T. # P.A. # 1224567				
RECIPIENT'S MEDICAL ASSIST	TANCE ID NO	MBER		1234307	RECIPIENT	ADDRESS (STREET.	CITY, STATE, 2	OP CODE)
1234567890								
RECIPIENT'S NAME (LAST, FIR	ST, MIDDLE	INITIAL)			609 W:			
Recipient, Ima	A.				Anyto	wn, WI 5555	55	
DATE OF BIRTH			6 SEX			OVIDER TELEPHONE	NUMBER	
MM/DD/YY				M F X	(XXX) XXX-XXXX		
BILLING PROVIDER NAME, ADD	DRESS, ZIP (CODE:				9 BILLING PROVIDE	R NO.	
I.M. Provider						87654321 10 DX: PRIMARY		
10 W. Williams						10.00		-d Wor
Anytown, WI 55	555					401.9 - 1	yperten	sion NUS
						250.0 - da	labetes	II (NIDDM)
						12 START DATE OF N/A	SOI:	13 FIRST DATE RX: MM/DD/YY
	15	16	17	18			19	20
PROCEDURE CODE	MOD	POS	TOS	DESCRIPTION	OF SERVI	CE	QR	CHARGES
W9930		4	1	HHN - initial visi	t		16	XXX.XX
	-	ļ ,	_					TOUR TOUR
				l visit/day x 2 da	ys/wk o	k 8 weeks		
W9930	_	4	1	HHN - initial visi			2	VV VV
W9930	-	4.	1	HAN - INICIAL VISI		2	XX.XX	
				1 visit PRN/month				
	+	-	-					-
							TOTAL	21
An approved authorizate imbursement is continged				ment.			CHARGE	XXX.XX
sistance Program payr	ment meth	nodology	and Poursement	orization expiration date. Rei alicy. If the recipient is enri- will be allowed only if the se J. M. Provida REQUESTING PROVIDER SIGNATURE	olled in a	Medical Assist	ance HMO HMO. st	
60.2				(DO NOT WRITE IN THIS S	DACE:			
AUTHORIZATION:				(DO NOT WHITE IN THIS S	AUC)			
20 - 20 - 20 - 20 - 20 - 20 - 20 - 20 -						PROCEDURE(S) AUT	HORIZED	QUANTITY AUTHORIZED

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								e quantity you
								provide is
DENIED - RE	EASON:					indicated		
						profession		
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DATE			CC	INSULTANT/ANALYST SIGNATURE			_	

APPENDIX 4b SAMPLE PRIOR AUTHORIZATION REQUEST FORM (PA/RF) HOME HEALTH NURSING AND AIDE SERVICES

MAIL TO:		PF	NOR AUTHO	RIZATION REQU		1 PROCESSING TYPE				
E.D.S. FEDERAL CORPO PRIOR AUTHORIZATION				PA/RF	(DO NOT WRIT	0				
6406 BRIDGE ROAD	UNII							120		
SUITE 88			_	CN # A.T. #					120	
MADISON, WI 53784-00	88		_		234567					
2 RECIPIENT'S MEDICAL ASSIST	ANCE ID NUI	MBER				4 RECIPIENT A	DDRESS (STREET,	CITY, STATE, ZI	P CODE)	
1234567890						(00 111				
3 RECIPENT'S NAME (LAST, FIR	ST, MIDDLE #	NITIAL)				609 Wi	n, WI 5555	5		
Recipient, Ima	1.0		6 SEX				WIDER TELEPHONE			
MM/DD/YY				м	FX	(XXX) XXX-XXXX	HOMBEN		
7 BILLING PROVIDER NAME, ADD	SRESS, ZIP C	CODE:				1	9 BILLING PROVIDE	R NO.		
I.M. Provider							87654321			
10 W. Williams							10 DX: PRIMARY		110.0	
Anytown, WI 55	555						401.9 hype	rtension	1 NOS	
,,							250.0 diab		(NTDDM)	
							12 START DATE OF	SOI:	13 FIRST DATE RX:	
				1				N/A	MM/DD/YY	
PROCEDURE CODE	15 MOD	POS	17 TOS	18	DESCRIPTI	ON OF SERVIC	E	QR	CHARGES	
W9930		4	1	HHN - f	initial vi	sit		87	XXX.XX	
				l visit	t/day x 3	days/wk x	29 weeks			
W9931		4	1	нна - :	initial vi	sit		203	XXX.XX	
				l visit	t/day x 7	days/week	x 29 weeks			
	1		-							
	+	-	-	-						
	-									
22. An approved authorizat	ion does r	not guara	ntee pay	ment.				TOTAL	21 XXX.XX	
Reimbursement is conting recipient and provider at for services initiated prior Assistance Program pays	the time	the ser	vice is	orization ex	epiration date	Reimburseme	nt will be in acc	cordance w	ith Wisconsin Medical	
authorized service is provi	ded, WMA	P reimbu	rsemen	t will be allo	wed only if the	e service is no	at covered by the	HMO.		
and the female			0	m /) . ,				art: 6/5/91	
23MM/DD/YY		24	d/.	711.77	wider				end: 12/31/91	
DATE					ROVIDER SIGNATURE					
AUTHORIZATION:				(DO NO	OT WRITE IN TH	IS SPAGE)				
							PROCEDURE(S) AUT	THORIZED	QUANTITY AUTHORIZED	
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3										
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APPENDIX 4c SAMPLE PRIOR AUTHORIZATION REQUEST FORM (PA/RF) HOME HEALTH THERAPY

MAIL TO:			PF	RIOR AUTHORIZATION R	1	1 PROCESSING TYPE			
E.D.S. FEDERAL COR		N		PA/RF (DO NOT W	RITE IN THIS SPA	(CE)			
PRIOR AUTHORIZATI 6406 BRIDGE ROAD	ON UNIT			ICN#					
SUITE 88					120				
MADISON, WI 53784-0	880		_	A.T. # P.A. # 1234567				500000	
		D AN IMPE		P.A. # 1234307	A DECIDIENT	ADDRESS (STRE	ET CITY ST	ATE ZIP CODE	
2 RECIPIENT'S MEDICAL ASS	SISTANCE	D NUMBE	н		4 RECIPIEN	ADUNESS (STRE	E1, G11, 31/	(TE, ZIP CODE)	
1234567890 3 RECIPIENT'S NAME (LAST.	FIRST, MID	DLE INITI	AL)		609 W	1110w			
Recipient, Ima	A.					m WT 555 ROVIDER TELEPH	55		
DATE OF BIRTH			6 SEX						
MM/DD/YY BILLING PROVIDER NAME.	ADDRESS	718 CODS		M F X	(۸۸۸	9 BILLING PROVI			
	ADDRESS.	ZIF CODE				87654321			
I.M. Provider						10 DX: PRIMARY			
10 W. Williams						429.2 - 0			
Anytown, WI 55	1333					11 DX: SECONDA	RY		
						250.0 - d	iabetes	II (NIDDM)	
						N/A	OF SOI:	MM/DD/YY	
PROCEDURE CODE	15 MOD	16 POS	17 TOS	18 DESCRIPT	ION OF SERVI	CE	19 QR	20 CHARGES	
PHOCEDORE CODE	1400	1.00	.00	DECOMPT				2.3.1000	
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		-	-						
	+	+	-						
		-	-						
							TOTAL	21	
22. An approved author Reimbursement is con	ization d	oes not	guaran	tee payment.			CHARGE	xxxx.xx	
recipient and provider:	at the tim	e the se	rvice is p	provided and the comp	leteness of th	e claim inform	ation. Payr	nent will not be made	
for services initiated pr Medical Assistance Pro	ior to app	proval or	afterau	thorization expiration	date. Reimbu	rsement will b	e in accord	lance with Wisconsin	
a prior authorized serv									
							sta	art: MM/DD/YY	
23 MM/DD/YY	7	24	d	M. Provide	er			end: MM/DD/YY	
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						professi			
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DATE		500	00	DNSULTANT/ANALYST SIGN	ATURE				
482-120									

APPENDIX 4d SAMPLE PRIOR AUTHORIZATION REQUEST FORM (PA/RF) DME

MAIL TO: E.D.S. FEDERAL CORP PRIOR AUTHORIZATIO 6406 BRIDGE ROAD SUITE 88 MADISON, WI 53784-00 2 RECIPIENTS MEDICAL ASS 1234567890 3 RECIPIENTS NAME (LAST.) RECIPIENTS NAME (LAST.) RECIPIENTS NAME (LAST.) 8 DATE OF BIRTH MM/DD/YY 7 BILLING PROVIDER NAME.	DN UNIT D88 ISTANCE II FIRST, MIDI	D NUMBER	AL)	PA/RF (DO NOT WE PA/RF (DO NOT WE ICN # A.T. # P.A. # 1234567		IE NUMBER		
I.M. Provider 10 W. Williams Anytown, WI 55						87654321 10 DX: PRIMARY 401.9 - h 11 DX: SECONDAI 250.0 - d 12 START DATE O N/A	iabetes	II (NIDDM) 13 FIRST DATE RX: MM/DD/YY
PROCEDURE CODE	15 MOD	POS	17 TOS	18 DESCRIPTI	ON OF SERV	ICE	QR	CHARGES
W0900		4	P	Commode			1	XX.XX
22 An approved authori Reimbursement is cont recipient and provider a for services initiated pri Medical Assistance Pro a prior authorized servi	ingent up t the time or to app gram pay	pon elig the sen roval or ment m	ibility o vice is p after au ethodol VMAP re	of the provided and the complete the provided and the complete the provided and the complete the provided and Policy. If the resimbursement will be a provided and provided an	date. Reimb ecipient is er illowed only	ursement will be prolled in a Med	in accord	lance with Wisconsin ance HMO at the time
DATE			F	(DO NOT WRITE IN TH				
AUTHORIZATION: APPROVED		GRA	NT DATE			PROCEDURE(S) AU	THORIZED	QUANTITY AUTHORIZED
	ASON:							
RETURN — RE	ASON:							
DATE		_	СО	NSULTANT/ANALYST SIGNA	TURE		_	